Guardianship: An Alternative to "I'm Sorry"*

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Introduction

Changes in involuntary commitment statutes for the mentally ill have dramatically altered the chain of events that take place when a family member brings a psychotic relative to the psychiatrist for hospitalization. The following hypothetical case example illustrates the problem.

Mr. A. was a middle-aged executive with a prior history of an affective disorder. He was taking lithium and doing well, until he began experiencing another episode of hypomania. Grandiosity and paranoia became prominent symptoms. Therefore, he resisted his wife's attempts to get him to see a doctor, or increase his lithium. Instead, he began secretly disposing of his daily dose of pills. The hypomania progressed to full manic symptomatology — wasting large sums of money, missing meals with the family and acting irrationally at his job. Finally, Mrs. A., with the help of other relatives, was able to force her husband to go to the emergency room in order to be seen by a psychiatrist. Subsequent to examining Mr. A., the psychiatrist spoke with the wife.

"I cannot help either your husband or you. He refused both medication and hospitalization, although I think he needs both. He is irrational and paranoid, but not imminently dangerous to anyone, and that is the only basis on which I can commit him to a hospital against his will. I'm sorry."

Despondent, the wife looks for her husband so they may leave. She finds him outside the emergency room, in the custody of a police officer. Her husband is being arrested for disorderly conduct after destroying records at the registration desk, records which he claimed were secret files on him.

The Problem

This tragedy portrays what has become an all too prevalent series of events: a seriously mentally ill patient refuses voluntary psychiatric treatment, is not commitable under state statutes for involuntary treatment, and therefore winds up in the criminal justice system,\(^1\) or even worse, dead.\(^2\)

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The problem for the concerned psychiatrist in such a situation is how to get the patient into a protected psychiatric inpatient setting and how to get the patient treated before one of these untoward events occurs. The former issue previously presented no problem. Patients could be hospitalized with little justification. But, because of problems with methods of treatment or lack of treatment once in the hospital, legislatures have enacted statutes that make involuntary admission more difficult. A recent example is the new Georgia mental health code which sets the criteria for involuntary treatment as:

A person who is mentally ill and (1) who presents a substantial risk of imminent harm to himself or others as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to himself or to other persons or (2) who is so unable to care for his own physical health and safety as to create an imminently life endangering crisis.

Numerous studies and articles have been written regarding the difficult problems of predicting dangerousness. Recently, a further problem has arisen – the standard of proof which is to be used for commitment. The Illinois State Supreme Court found that a “clear and convincing” evidence standard was sufficient. However, the New Hampshire Supreme Court and a Massachusetts Appellate Court have stated that the “beyond a reasonable doubt” standard must be used. The Texas Supreme Court allowed a “preponderance of the evidence” standard, but a review may be upcoming in another case where the plaintiff is seeking that the “beyond a reasonable doubt” standard be utilized. Should the “beyond a reasonable doubt” standard become widely accepted, the likelihood of someone’s being judged involuntarily commitable will diminish even further, given the psychiatrist’s limited ability to predict dangerousness with this high degree of certainty.

However, let us assume that the patient is committed involuntarily to a treatment facility. It would seem likely that he would receive appropriate treatment, given the numerous successful right-to-treatment suits and state legislation enacting the right to treatment. Yet this is not necessarily the case. Inadequacies still exist in treatment institutions, as improvements are slow in coming. Abuses also exist which have led to right-to-refuse-treatment suits. A prime example is the suit in Massachusetts of Rogers v. Okin. There, the plaintiffs obtained a temporary restraining order prohibiting the defendants from forcibly administering medication to them against their will, lacking any formal determination of the plaintiffs’ incompetency. They have charged the defendants with assault and battery and false imprisonment. The trial is currently in process, and has been for a number of months. Thus the chaos described vividly in the amicus curiae brief of the Massachusetts Psychiatric Society will continue until the case is settled. Moreover, the involuntarily committed patients who are involved will still not get treatment.

Proposed Solution

How then is the psychiatrist going to be of help to the severely ill patients who do not qualify for commitment or who refuse treatment in the
hospital? My suggestion is that the doctor consider utilizing the statues on civil incompetency and guardianship proceedings to solve these problems. In the first instance, where the patient does not meet the dangerousness or "imminently life endangering" standard for commitment, hospitalization might be accomplished consequent to a formal court hearing where the patient is found incompetent and a guardian is appointed. The guardian could then admit the patient to the hospital for care and treatment. Similarly, in the second case, where a patient refuses treatment either in or out of a hospital, if there is a legal finding of incompetency, the guardian can consent to the treatment.

Thus, when the psychiatrist sees a person for commitment, but finds the person does not meet the standard, instead of merely saying, "I'm sorry, I can't help," he can suggest the following series of events: the petitioner should seek to have the person found incompetent, have a guardian appointed, and have the guardian admit his ward to the hospital for treatment.

Naturally, this should only be done if the psychiatrist believes the patient is, in fact, in need of hospitalization, but is incompetent to make a rational decision as to his or her need for treatment. Even if the psychiatrist does find that the patient is commitable, he can suggest the same procedure — again presuming that the patient is incompetent. If the procedure were successful, the guardian could then authorize the appropriate treatment which the patient refused.

This is the essence of the proposed solution. In order to make it both understandable and useful, an examination of the theory of incompetency and guardianship is necessary. Then, both the advantages and disadvantages of the proposal will be considered, followed by a suggestion as to what the examination should include and for whom it would be appropriate.

Incompetency and Guardianship

In general, all persons who have reached the age of majority are presumed competent. This means that they can manage their own affairs in regard to both person and property. For example, an adult is presumed competent to make contracts, buy and sell goods, execute a will, and make decisions about his own well-being, including medical care.

Incompetency occurs when a person cannot carry out some or all of these functions. At that point, a need arises for someone to help him with those functions he cannot manage on his own. The historical root of finding someone incompetent was to protect his property, to ensure that he did not waste away his substantial assets due to a mental infirmity. The guardian's function was to watch over and administer the ward's estate. The concept has been expanded over the years to include use of the statutes for finding a person incompetent to care for his own needs, and thus, a guardian of "the person" has come into being. In short, a person can be found incompetent in regard to his ability to care for himself or for his property. Likewise, a guardian can be appointed to care for the person or his property. A different guardian can be appointed for each function, or the same person can serve as guardian for both. Although guardians have been appointed solely for the estate, Stone quotes a study stating that there has never been a case known
where a guardian has been appointed solely for the person.21 Perhaps then, because of the focus on property rather than person, it is not surprising that the criteria for finding someone incompetent are not exacting. For example, one legal text on the subject cites standards such as weakness of mind, which need not be either an entire absence of reasoning or a showing of lunacy.22 Another text gives the standard as “whether there is such mental impairment as renders the subject incapable of understanding and acting in the ordinary affairs of life.”23 The process of finding someone incompetent is set in motion, usually at the request of a relative who has filed a petition with the court of jurisdiction, alleging the existence of incompetence in their spouse, parent, sibling or offspring. However, depending on the jurisdiction, a variety of other people can file such a petition, including an officer of the state.24,25

Once the petition is filed, the court issues a writ to have the alleged incompetent brought before the court; and an inquiry is conducted. The alleged incompetent has certain rights, which vary depending on the jurisdiction. They may include the right to notice of the hearing in a sufficient manner, the right to be present, and the right to counsel.26 The last may have to be at the subject’s own expense, as “very few jurisdictions provide for appointed counsel for the alleged incompetent.”27

At the hearing, the petitioner provides evidence of the subject’s incompetence. This may consist of testimony of those who know the alleged incompetent, such as relatives or clergy. However, often the only testimony is a brief affidavit from the physician who has examined the patient, stating his conclusion that the patient is incompetent. It may also state a diagnosis such as chronic brain syndrome or mental retardation. (The aged and retarded are, in fact, the classes of people generally involved in incompetency proceedings.) Thus the hearing is quite brief.

If the subject is found to be incompetent, he becomes a ward of the court and a person or agency is generally, although apparently not always,28 appointed as guardian. If partial incompetency is found, then a limited guardian may be appointed. Also, some jurisdictions allow for temporary guardianship.29 In any case, this guardian should be someone whose interests do not conflict with those of the incompetent.30

The guardian of a person and his property has certain duties. In regard to the person, the guardian is responsible for his ward’s health, education, and support.31 However, he can neither waive nor terminate the ward’s rights without the court’s approval,32 nor can he deny the ward’s freedom without good reason.33

Advantages

As previously stated, the primary gain from this proposal is that a segment of the population that currently cannot get treatment, will get the proper help, rather than being jailed, or worse. These people aren’t now getting treatment because they are neither dangerous enough to be committed, nor rational enough to recognize the need for and seek psychiatric care. If this irrationality is such that the patient can be found incompetent and have a guardian appointed, perhaps the guardian can then get his ward into the hospital. Recently, North Carolina has made this procedure available in a
new guardianship statute. One hopes that other legislatures and courts will follow suit so that patients who need treatment can get it before they become dangerous and injure either themselves or others.

Should the court refuse to allow the guardian to effect hospitalization, as has already occurred in one case involving a limited guardianship, the patient still can be treated as an out-patient. If the guardian can get the patient to the psychiatrist's office, medication can be prescribed, even if the patient objects. Because of the patient's incompetence, the responsibility for obtaining treatment for him falls on his guardian. Thus, the guardian can agree to the treatment plan for his ward, and treatment can be administered, even over the objection of the patients.

The same situation holds true should the incompetent patient gain admission to the hospital. The guardian is the one who must give consent before any treatment can be administered to his ward. Once this consent is obtained, treatment may proceed, regardless of the wishes of the incompetent patient.

It is important to point out that involuntary commitment and competency are two separate issues. Just because a patient is found committable, it does not necessarily mean he is incompetent to make decisions regarding treatment. Therefore, as Roth has previously noted, if the patient is incompetent in this regard, it is essential that this adjudication be made by the court in addition to having him involuntarily committed. This outcome keeps the doctor out of the role of parens patriae. It also precludes the initiation of suits by patients for assault and battery, because they were treated against their will without being found incompetent.

The thesis of this paper is not meant to encourage treating patients against their will when they can make competent, rational decisions regarding treatment. However, if a patient lacks the capacity to give or withhold "informed consent," then consideration should be given to obtaining a guardian to expedite routine psychotherapeutic measures. For more intrusive procedures, such as E.C.T., perhaps even further review should be required, such as in California.

Another benefit from utilizing this proposal is that it may make the incompetent eligible for services which would otherwise be unavailable. For example, the state of Washington has mandated that incompetent adults may receive protective services which are primarily designed for shielding children from abuse and neglect. Potentially, this could occur in other states.

Since the patients are wards of the court, it is the court's duty to see that they are properly cared for. Therefore, if no personal guardian is available, seemingly, the court should be responsible for providing at least protective shelter through a public guardianship. Payson has suggested the institution of a professional guardianship program with an advisory counsel as a means of providing service to, at least, the incompetent person who must rely on the court as his sole guardian.

In the cases where there is a family member available to act as guardian, further advantages, in regard to long term care, may accrue to the patient. The guardian will be the one who is responsible for making treatment decisions. Accordingly, that family member is involved in the treatment
from the beginning. This situation might well help that person to gain an appreciation of both the illness and the treatment process. Then he or she will see the benefit of ensuring that the patient receives outpatient care after discharge from the hospital, or even after the patient regains competency, should this happen. Moreover, the guardian may share the responsibility of treatment decision-making with other family members. This course of events would present the physician with an opportunity to aid and encourage an enduring, supportive family network for the patient’s benefit.

Last, but not necessarily least, in terms of benefits that can accrue from guardianship, is the purpose for which the statutes were enacted—preservation of estate. Many of the patients will have little or no estate to preserve, but even a social security or disability check can be put to good use by the guardian, rather than wasted or lost by an incompetent patient. Where the patient’s assets are more substantial, guardianship prevents financial ruination of other family members and the patient himself. For the manic patient who was the subject of our drama, guardianship would have prevented him from draining his bank account, preserving the funds for rational use by him after he regains his competency.

Disadvantages

There are six areas in which this proposal may be problematic. These vary in importance and in potential for resolution.

The first area of potential problem is that the procedure may have limited applicability. In a Washington case, a limited guardian sought court approval to have her ward admitted to a mental hospital for a thirty day observation period after twice failing in attempts to have the ward committed as dangerous. The Superior Court granted the request, but on appeal the decision was reversed. The State Supreme Court refused to hear the case. Perhaps the outcome would have been different had the situation been one of full rather than limited guardianship. If other states follow this decision, the applicability of the proposal will be limited. One hopes, however, that other states instead will follow the North Carolina model which allows a guardian the right to hospitalize his ward without involuntary commitment proceedings.

The second area of concern is that this proposal is potentially regressive from a historical viewpoint, with the patient winding up in the hospital without any rights. The significant factor which one hopes will prevent abuse is that there is a guardian. Therefore, the physician is not free to treat the patient any way he sees fit, but rather must get informed consent from the guardian. Another means of preventing a loss of patient rights is for the psychiatrist who examines a patient for civil incompetency to be specific in both examination and report writing. If the patient retains competency in some areas, the physician should so note. In addition, if the doctor finds total incompetency, but also an expectation that the patient will recover either partially or completely with treatment, this should be noted as well. This may result in either limited or temporary guardianship, if the state statute recognizes these.

A third area of conceivable difficulty is that of overdiagnosis. Physicians are quite intelligent, knowledgeable and insightful people. Patients
sometimes are much less so, even competent ones.\textsuperscript{50-51} Since the standards for finding someone incompetent are so vague, the physician has a great deal of leeway. In order to be of optimal help to the patient, the examiner must do a thorough job, but use his own good judgment in terms of what is expectable and acceptable in terms of the patient's competency.

The next problem area involves abuses that already exist in the guardianship process. The first of these is where a child or other relative seeks to have an aged parent declared incompetent and "put away," in order that the petitioner may gain control over the estate, to prevent its being wasted away. Here, the petitioner's concern is more for the estate than the person. The second abuse occurs in the system itself. Hearings may last less than two minutes, sometimes \textit{ex parte}, and even without counsel for the alleged incompetent.\textsuperscript{52,53,54}

Of these two abuses, the first may be insoluble if the person needs a guardian and the petitioner is the only willing and available relative. In such a situation, the examining psychiatrist should make quite sure that the patient is incompetent, not merely enjoying himself by spending surplus money freely, having already made arrangements for his essential well being.\textsuperscript{55} If the evaluator does find incompetency, he can report such. He can also make recommendations for guardianship arrangements.

The second abuse should be correctable. Through legislation and suits, the system can be improved. Unfortunately, however, a recent class action suit in Illinois challenging some of the procedures procedures was unsuccessful.\textsuperscript{56} The American Bar Association Commission of the Mentally Disabled has noted these abuses in guardianship proceedings and has published a suggested revision devised by the Mental Health Law Project.\textsuperscript{57} The doctor can do his part to improve the process by submitting a thorough report, instead of rendering only a diagnosis and a conclusion of incompetence.

The fifth problem is the delay which is necessitated by the court process. In contrast to commitment, where the patient can be taken from the emergency room to the hospital for in-patient confinement pending the hearing on commitability, the incompetent patient cannot be so handled. After the petition alleging incompetence is filed with the court, an examination is ordered, and a court date is set. This may be weeks in the future. This necessitates an unfortunate delay in treatment, since neither hospitalization nor medication can be given over the patient's objection until the hearing is completed, a guardian is appointed, and that person agrees to the treatment program for his ward. Should the person become commitable in the interim, that option is still available. Even if commitment is accomplished, however, the incompetency hearing should not be aborted. It may still be necessary to get the hospitalized patient treated.

The final drawback is that the patient becomes saddled with the label of "incompetence." Perjorative-sounding labels are a sad fact of life. However, the patient has already been called other such names by relatives and associates. Moreover, having to suffer the consequences of such a label seems a small price to pay for protection and treatment.

\textbf{The Examination}

In the interest of space, I will comment only briefly on this aspect of the
process. The essence of the examination is a good history combined with a
detailed mental status examination. Judgment, insight, presence of delusions,
memory, orientation, quality of thought processes, and intellectual
capabilities all need special attention, although all parts of the mental status
need to be assessed. In regard to standards for competency to consent or to
refuse treatment, the listener (reader) is referred to articles by Roth and
Meisel. Another possible standard is that cited in the Kaimowitz case
from Michigan: "Competence . . . is the ability of the subject to understand
rationally the nature of the procedures, its risks, and other relevant
information. . . ."60

Finally, it is appropriate to mention the types of patients who might be
appropriate for incompetency proceedings and guardianships. To date, the
process has been utilized primarily for the aged and the retarded. It has been
used in the past also for chronic alcoholics who are regularly and repeatedly
under the influence, who can be expected to continue being so in the future,
and who are incompetent while intoxicated, but not necessarily when
sober.61,62

In addition to these persons, those who are acutely psychotic for whatever
reason are likely candidates for this process. Examples would be some
schizophrenic, depressive, and manic patients. Naturally, not all of these
people will be incompetent, but many of them will. Frequently, they are not
commitable and refuse treatment, so that without guardianship, they will
not receive treatment.63

Summary

The severely mentally ill patient who is neither imminently dangerous to
himself or others, nor gravely disabled to the extent that his life is in
immediate danger, is in a category of people who are not currently getting
appropriate psychiatric care. These people irrationally refuse voluntary
treatment and are not commitable. The proposed intervention is the use of
incompetency hearings and guardianship statutes to secure needed treatment.

When a psychiatrist examines a patient for commitment, but finds that
the patient does not meet the criteria and the patient refuses voluntary
treatment, his role as physician is to suggest this process to the petitioner. He
may hope that this action will restore him to the role of healer in the drama,
rather than feeling like the buffoon whose only line is "I'm sorry, I can't
help."

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15. *Rogers v. Okin*, CA 77-1201 (1st Cir., in progress)

16. E.g. supra note 4 at 88-502.3 and 88-502.4

17. *Supra*, note 3, at 163, 164


23. Chap. 725, S.B. 142 (Jun 24, 1977), as reported in 2 Mental Disability L Rprr 194 (1977)

24. Chap. 80 S.B. 2872 (May 24, 1977), as reported in 2 Mental Disability L Rprr 194 (1977)


29. *Supra*, note 35


31. *Supra*, note 5, at 163

32. E.g., *In re Tyrell*, as reported in supra, note 5, at 165

33. *Supra*, note 52

34. *Supra*, note 54

35. *Supra*, note 34

36. *Supra*, note 34

37. *Supra*, note 34

38. *Supra*, note 34

39. *Supra*, note 34
57. 2 Mental Disability L Rptr 444, Jan-Feb issue, 1978
58. Supra, note 40
59. Supra, note 41
61. Supra, note 24, at 547
63. See, for e.g. supra, note 2, at 496; Surawicz FG: Letter to the editor: committing violent manic patients. Am J Psychiatry 134:740, 1977